REPORT TO THE CONGRESS

Improvements Needed In Processing Medicare Claims For Physicians' Services In Texas B-164031(4)

Social Security Administration

Department of Health, Education, and Welfare

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

DEC. 31, 1970

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D C 20548

B- 164031(4)

To the President of the Senate and the
Speaker of the House of Representatives

This is our report on improvements needed in processing Medicare claims for physicians' services in Texas The Medicare program is administered by the Social Security Administration, Department of Health, Education, and Welfare

Our review was made pursuant to the Budget and Accounting Act, 1921 (31 U S C 53), and the Accounting and Auditing Act of 1950 (31 U.S C 67)

Copies of this report are being sent to the Director, Office of Management and Budget, and to the Secretary of Health, Education, and Welfare

Elmer B. Staats

Comptroller General
of the United States

Contents

ABBREVIATIONS

EDS	Electronic Data Systems Corporation
EDP	electronic data processing
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
SSA	Social Security Administration

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

IMPROVEMENTS NEEDED IN PROCESSING MEDICARE CLAIMS FOR PHYSICIANS' SERVICES IN TEXAS

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D I G E S T

WHY THE REVIEW WAS MADE

The General Accounting Office (GAO), as part of its continuing review of the Medicare program, examined into whether the charges for physicians' services, as established under the supplementary medical insurance portion of the Medicare program in Texas, were reasonable and consistent with the applicable law and regulations, whether a means had been established to identify physicians who might have provided unnecessary services, and whether amounts being paid for electronic data processing services for Medicare claims were reasonable

Legislation enacted by the Congress establishing the Medicare program provides that payments for physicians' services be based on reasonable charges and that the determination of the reasonableness of the charges take into account customary charges for similar services made by the physicians, as well as the prevailing charges in the locality.

Medicare is administered by the Social Security Administration, Department of Health, Education, and Welfare (HEW). Under a contract with the Social Security Administration, Group Medical and Surgical Service (Texas Blue Shield) has been processing and paying Medicare claims for physicians' services in Texas Organizations performing such services are referred to as carriers

During fiscal year 1969, Texas Blue Shield made supplementary medical benefit payments amounting to about $82 million. Total payments made by all carriers amounted to about $1 5 billion, of which about 95 percent was for physicians' services

FINDINGS AND CONCLUSIONS

GAO's review of a random sample of Medicare claims processed by Texas Blue Shield during a 3-month period in calendar year 1967 showed that:

--Payments were made in excess of the charges established by Texas Blue Shield as reasonable for the services. (See p 13)

--Duplicate payments were made. (See p 16)

--Payments were made without obtaining adequate evidence that the charges were reasonable That was due, in part, to the latitude of judgment a carrier could exercise in making reasonable-charge determinations (See p 19)

--Errors were made in coding and recording customary-charge data These errors contributed to improper payments (See p. 25.)

The results obtained from GAO's examination of claims processed in the 3-month period did not provide an adequate basis for statistically projecting its findings to the entire year Since the average number and types of claims processed monthly in the 3-month period covered by this review were about the same as the monthly average for the entire year and since the same claims-processing procedures were followed for almost all the year, it is probable that the problems noted are typical of the entire year If that was the case, then during that year Texas Blue Shield paid about $1 million in excess of reasonable charges, paid duplicate claims totaling about $1 million, and paid claims amounting to about $15 million without obtaining adequate evidence to determine the reasonableness of the charges (See p. 12.)

GAO's review showed also that Texas Blue Shield had not implemented appropriate safeguards, contrary to the requirements of its contract with the Secretary of HEW, against payments for unnecessary medical services (See p 26)

Subsequent to 1967 Texas Blue Shield revised its claims-processing procedures, however, a review of its activities completed by the Social Security Administration in October 1969 showed that certain problems still existed Adequate determinations of the reasonableness of charges for certain types of medical services still were not being made, duplicate payments were still being made, and an effective method of minimizing payments for unnecessary medical services still had not been implemented (See p 31)

During the period June 1966 through January 1968, Texas Blue Shield entered into a series of subcontracts for electronic data processing services without obtaining the required prior approval from the Secretary of HEW The subcontracts did not have the required access-to-records clause giving the Secretary of HEW and GAO the right to examine pertinent books and records of the subcontractor Since HEW did not have access to those records, the Social Security Administration was committed to making payments that could have amounted to as much as $6 million without having contractual authority to review the pertinent cost records to determine the reasonableness of the subcontractor's charges. (See p 35.)

The Social Security Administration and Texas Blue Shield did not agree on whether prior approval of the subcontracts or the access-to-records clause was mandatory GAO believes that such questions could have been resolved promptly if the language of the dispute clause included in the

carriers' contracts with the Secretary of HEW had been broad enough to cover these kinds of disagreements

Although some actions have been taken by the Social Security Administration to improve the processing of Medicare claims by carriers in general and to improve its overall administration of the program, GAO believes that further improvements should be made

RECOMMENDATIONS OR SUGGESTIONS

GAO is recommending that the Secretary of Health, Education, and Welfare provide for

--More effective surveillance by the Social Security Administration of carriers' claims-processing activities (See p. 34)

--An evaluation by the Social Security Administration of the effectiveness of the corrective action taken or planned by Texas Blue Shield to improve claims processing, detect duplicate claims, and minimize payments for unnecessary medical services (See p 34)

--A review and evaluation of the Social Security Administration's current regulations which allow carriers to make certain assumptions concerning the nature and extent of services provided, to determine how much latitude the carriers should have in determining the reasonableness of charges (See p. 34)

--Clarification of the circumstances under which prior approval by the Social Security Administration is required for subcontracts awarded by Medicare carriers (See p. 43)

--Broadening of the disputes clause in the carriers' contracts with HEW to cover all disputes except matters relating to the Secretary's directives and regulations governing administration of the Medicare program and termination of the contracts (See p 43)

AGENCY ACTIONS AND UNRESOLVED ISSUES

HEW advised GAO that it had taken and was taking steps to bring about further improvements in the administration of the Medicare program Those improvements included the assignment of onsite representatives at Texas Blue Shield and other large carriers to study the carriers' claims-processing activities and included also a directive to Texas Blue Shield to develop a program for identifying duplicate payments made in the past and to estimate the cost and time required to recover these payments. (See p. 30)

GAO was advised also that instructions had been issued prescribing for each carrier certain controls to minimize payments for unnecessary medical services (see p 30) and that the Social Security Administration was negotiating revisions to the carriers' contracts that would require the carriers to submit for review and approval all subcontracts involving major functions or substantial Medicare funds (see p 42).

MATTERS FOR CONSIDERATION BY THE CONGRESS

This report is being issued to the Congress because of its continuing concern over the rising costs of medical care being charged to the Medicare program

CHAPTER 1

INTRODUCTION

The General Accounting Office has made a review of selected aspects of the supplementary medical insurance benefits portion (part B) of the Health Insurance for the Aged (Medicare) program administered by the Social Security Administration (SSA), Department of Health, Education and Welfare. Part B of the Medicare program covers physicians' services and a number of other medical and health benefits. Payments for these services and benefits are made primarily by some 50 separate organizations under contract with HEW. These organizations are referred to as carriers.

Our review--which was made at Group Medical and Surgical Service (Texas Blue Shield), the carrier that makes payments for part B services to beneficiaries in Texas--was limited to the examination of (1) a random sample of claims processed and paid by Texas Blue Shield for part B services to determine whether the payments were made on the basis of reasonable charges, (2) the carrier's procedures designed to minimize payments for unnecessary medical services, and (3) the carrier's contractual arrangements for data processing services including the efforts made by SSA and Texas Blue Shield to determine the reasonableness of the charges for these services. The scope of our review is discussed in more detail on page 44.

Principal officials of HEW responsible for administration of the activities discussed in this report are listed in appendix II.

CHAPTER 2

DESCRIPTION OF PERTINENT FEATURES OF THE MEDICARE PROGRAM

Title XVIII of the Social Security Act (42 U.S C 1395), enacted on July 30, 1965, established the Medicare program, effective July 1, 1966, to provide persons over age 65 with two basic forms of protection against the costs of health care. One form of protection, designated as Hospital Insurance Benefits for the Aged (part A), covers inpatient hospital services and is financed by a special social security tax paid by employees and their employers and by self-employed persons.

The second form of protection, which is the subject of this report, is a voluntary program, designated as the Supplementary Medical Insurance Program for the Aged (part B), that covers phyiscians' services and a number of other medical and health benefits. Part B is financed by monthly premiums collected from each participating beneficiary who has elected to be covered by the program. Effective July 1, 1970, the monthly premium increased from $4 to $5.30. This amount is matched by an equal amount appropriated from general funds of the Federal Government. The beneficiary is responsible for the first $50 for covered services in each year. This $50 is referred to as the deductible. Of the reasonable charges for covered services in excess of $50 in each year 80 percent are paid under part B of the Medicare program.

According to SSA about 19.2 million persons were enrolled for supplementary medical insurance benefits as of July 1, 1969. As of that date enrollment in Texas was about 939,000 persons.

PAYMENTS FOR SERVICES ON THE BASIS OF REASONABLE CHARGES

The Congress, in establishing the Medicare program, provided that payments for physicians' services under part B be made on the basis of reasonable charges and that, in

determining reasonable charges, the customary charges made by the physician for his services, as well as the prevailing charges in the locality for similar services, be considered.

In regulations promulgated to implement the reasonable-charge criteria set forth in the Medicare law, SSA has defined "customary charge" as the uniform amount which a physician or supplier charges in the vast majority of cases for a specific medical procedure or service.

SSA regulations define "prevailing charges" as those charges which fall within the range of charges most frequently and most widely used by physicians in a locality for a particular medical procedure or service. SSA regulations also state that, except for unusual circumstances, the upper limit of the range of prevailing charges represents an overall limitation on charges which the carrier should accept as reasonable for a given medical procedure or service.

In other words, in reviewing and paying claims under part B of the Medicare program, the carrier is supposed to determine that the charge to be allowed does not exceed either (1) the individual physician's customary charge for the service rendered or (2) the upper limit of the prevailing charges in the area. Furthermore, the reasonable charge cannot exceed the actual charge made by the physician in a particular case.

METHODS OF PAYMENT FOR MEDICAL SERVICES

Under part B of the Medicare program, payments in excess of the $50 deductible may be made either to the physician (assignment method) or to the beneficiary (direct method). The choice is a matter of agreement between the physician and the beneficiary. Under the assignment method, the physician agrees that he will accept the reasonable charge as full payment for his services and that he will not bill the beneficiary for more than 20 percent of the reasonable charge. Under the direct method, the beneficiary, when applying for payment, must support his claim with an itemized bill from the physician. The beneficiary is then paid 80 percent of the reasonable charge. Under the direct method, the payment of the physician's fee is a matter between the physician and the beneficiary.

CARRIERS' ROLE IN ADMINISTERING MEDICARE PROGRAM

Title XVIII of the Social Security Act authorizes the Secretary of HEW to enter into contracts with carriers to participate in the administration of benefits under part B of the Medicare program The carriers' functions include (1) determining the rates and amounts of payments on a reasonable-charge basis, (2) determining the medical necessity of the services, and (3) receiving, disbursing, and accounting for Medicare funds

The reports of the House Ways and Means Committee and the Senate Finance Committee on the bill (H.R. 6675) that became the Medicare law expressed the view that the medical benefits under part B should be administered by private carriers because private insurers, group health plans, and voluntary medical insurance plans were experienced in reimbursing physicians Both committee reports also expressed the intent that the Secretary of HEW should, to the extent possible, enter into contracts with a sufficient number of carriers, selected on a regional or other geographical basis, to permit comparative analyses of their performances

As of July 1, 1969, SSA had contracts with 33 Blue Shield organizations, 15 commercial insurance companies, and one State agency, to act as carriers under part B During fiscal year 1969, benefit payments made by carriers under part B amounted to about $1 5 billion, of which about 95 percent was for physicians' services. The carriers' administrative costs reimbursed by SSA during this period amounted to about $118 million

CARRIER'S AGREEMENT WITH SECRETARY OF HEW

Texas Blue Shield is the carrier responsible for making payments in the State of Texas under part B of the Medicare program. Its counterpart for the Medicare, part A, program is Group Hospital Services, Inc. (Texas Blue Cross). Texas Blue Cross and Texas Blue Shield have a common directorate, and, under an agreement approved by SSA, Texas Blue Cross has been the contracting and paying agent for Medicare

operations in Texas even though Texas Blue Shield contracted to serve as the Medicare, part B, carrier in Texas

The contract between Texas Blue Shield and the Secretary of HEW was entered into on June 22, 1966, and was effective for the period from February 1966 through June 1967. The contract is automatically renewed each year unless either party to the contract gives written notice of its intention to not renew

The contract contains the following provisions relating to access to records and subcontracting.

"Article XIX - EXAMINATION OF RECORDS"

* * * * *

"B The Carrier further agrees to include in all his subcontracts under this agreement a provision to the effect that the subcontractor agrees that the Secretary and the Comptroller General of the United States shall, until the expiration of three years after final payment for the term of this agreement, have access to and the right to examine any directly pertinent books, documents, papers, and records of such subcontractors, involving transactions related to the subcontract."

"Article XVII - SUBCONTRACTING

"The Carrier shall not enter into any subcontract to perform any or all of its functions under this agreement unless such subcontract is approved by the Secretary, and shall enter into leases and into purchase orders for articles, supplies, equipment, and services only in the manner provided in Article I of the appendix to this agreement For the purpose of this Article, a subcontract is a contract between the carrier and a third party to perform any of the functions and duties set forth in this agreement "

Article I of the appendix provides, in part, as follows:

> "A The Carrier may enter into leases and may purchase articles, supplies, equipment and services which are necessary for the performance of the work required under this agreement, except that the following shall require prior written approval of the Secretary: (1) *** (2) purchase orders for materials, as herein specified, or for services, or leases for equipment, which are primarily to be used for the administration of this agreement, but only if such purhase orders or leases exceed $25,000 if on a fixed price basis, ***."

During fiscal year 1969, Texas Blue Shield made part B benefit payments amounting to about $82 million. Of that amount, about $28 million was applicable to physicians' surgical services, about $51 million was applicable to physicians' medical services, such as office visits, and about $3 million was applicable to other services provided to beneficiaries, such as the use of medical equipment, the use of ambulances, and laboratory fees.

UTILIZATION REVIEW REQUIREMENTS

Texas Blue Shield's contract with the Secretary of HEW provides, in part, as follows:

> "The Carrier shall (A) assist persons who furnish services in the development of procedures relating to utilization practices, (B) make studies of the effectiveness of such procedures and methods for their improvement, and (C) assist in the application of safeguards against unnecessary utilization of services furnished eligible individuals." (Underscoring supplied.)

The contract provides also that Texas Blue Shield comply with the regulations and instructions prescribed by the Secretary of HEW for administration of the contract.

Instructions issued by SSA direct that the carrier's claims review process include methods for ensuring that medical insurance payments are made only for medically necessary covered services These instructions direct also that, if--after appropriate technical consultation--a carrier concludes that a service for which a claim has been made was not medically necessary or that the claim, as represented, improperly reflects the amount or character of service rendered, the carrier be required to adjust or reject the claim The instructions direct further that the carrier establish methods and procedures for identifying patterns in which the nature or frequency of medical services rendered deviate from established norms

SURVEILLANCE OF CARRIERS' ACTIVITIES

SSA contract performance review teams make periodic onsite visits to observe and analyze, among other things, the carriers' claims-processing procedures and the application of the customary- and prevailing-charge criteria. In addition, the HEW Audit Agency audits the carriers' costs of administering the program and reviews other carrier activities, such as claims processing.

SSA made a contract performance review at Texas Blue Shield in March 1967 and issued a report on the results of its review in May 1967 Also the HEW Audit Agency issued a report on the results of its review of Texas Blue Shield activities in October 1967 Although the audit report contained comments and a recommendation concerning Texas Blue Shield's subcontract for data processing services (see ch 4), neither the Audit Agency's report nor the SSA report on its contract performance review commented on the procedural inadequacies noted during our review (see ch 3) A second contract performance review was completed by SSA at Texas Blue Shield in October 1969.

We were advised by the HEW Audit Agency that it was currently giving more audit attention to claims paid by carriers, to determine whether payments had been made in accordance with law and regulations

CHAPTER 3

NEED FOR MORE EFFECTIVE SURVEILLANCE OF CARRIERS' CLAIMS-PROCESSING ACTIVITIES

We believe that there is a need for SSA to closely monitor the manner in which carriers process claims for supplementary medical insurance benefits, principally for physicians' services. Our review of a random sample of claims for supplementary medical insurance benefits paid by Texas Blue Shield during the 3-month period ended November 1967 showed that (1) benefit payments had been made in excess of reasonable charges, (2) duplicate payments had been made, (3) payments had been made without obtaining adequate evidence that the charges were reasonable, and (4) errors in coding and recording customary-charge data had contributed to improper payments. Our sample consisted of 400 claims, all of which we examined for evidence of duplicate payments and 100 of which we examined in detail for propriety and accuracy of payments.

Although SSA was aware, as early as September 1966, that Texas Blue Shield's method for evaluating the reasonableness of physicians' charges did not comply with applicable law and regulations, it was not until early 1968 that Texas Blue Shield began applying appropriate reasonable-charge criteria in processing claims for physicians' services.

Similarly, Texas Blue Shield's procedural inadequacies, which resulted in the deficiencies enumerated in items (2), (3), and (4) above, were not corrected nor was action initiated to correct them until 1968. We estimate that, during the 3-month period covered by our review, Texas Blue Shield paid about $235,000 in excess of reasonable charges, made duplicate payments of about $270,000, and paid about $3.7 million without obtaining adequate evidence as to the reasonableness of the amounts charged for services provided to beneficiaries.

The results obtained from our examination do not provide an adequate basis for statistically projecting our findings to the entire calendar year 1967. Since the

average numbers and types of claims processed monthly in the 3-month period covered by our review was about the same as the monthly average for the entire year and since the same claims-processing procedures were followed for almost all of calendar year 1967, it is probable that the problems noted during our examination are somewhat typical of the entire year. If this was the case, it would indicate that during calendar year 1967 Texas Blue Shield made (1) payments amounting to about $1 million in excess of reasonable charges, (2) duplicate payments amounting to about $1 million, and (3) payments amounting to about $15 million without obtaining adequate evidence of the reasonableness of charges.

Texas Blue Shield had not implemented appropriate safeguards designed to minimize payments for unnecessary medical services, which safeguards were required by its contract with the Secretary of HEW, with the result that Texas Blue Shield had no assurance that the payments were made for services which were medically necessary. A review by an SSA contract performance review team of Texas Blue Shield's activities showed that, as of October 1, 1969, it still did not have an effective review program to ensure that the services being paid for had been medically necessary.

In our opinion, more effective surveillance by SSA of Texas Blue Shield's activities relating to the supplementary medical insurance benefits program would have resulted in strengthening procedures and controls for processing claims and in significant reductions in the amounts paid for physicians' and other medical services Our findings are discussed in greater detail in the following sections of this chapter

PAYMENTS IN EXCESS OF REASONABLE CHARGES

In examining a random sample of 100 claims processed during the 3-month period and comparing the charges allowed with the charges that Texas Blue Shield had determined to be customary and prevailing for the services for which payments were made, we found that, for 46 services on 23 claims, Texas Blue Shield had paid about $86 in excess of the reasonable charges for the services. We believe that this amount was paid because Texas Blue Shield had not

followed SSA criteria for determining the reasonableness of physicians' charges but had used its own criteria which included establishing limits within which all charges would be allowed.

Applying the results obtained from our examination of the sample to all claims processed during the 3-month period, we estimate that Texas Blue Shield paid about $235,000 in excess of reasonable charges during the period. If the amount paid in excess of reasonable charges during this period is indicative of the entire year, Texas Blue Shield could have paid about $1 million in excess of reasonable charges during calendar year 1967.

Texas Blue Shield's contract with the Secretary of HEW provides, in part, that

> "The carrier shall determine reasonable charges with respect to services to any eligible individual ***. In determining the reasonable charge for such services, the carrier shall take into consideration the customary charges for similar services generally made by the physician or other person furnishing such services as well as the prevailing charges in the locality for similar services "

At the start of the Medicare program, Texas Blue Shield initiated a procedure under which charges, up to a predetermined amount for each type of service, were considered reasonable and were paid without regard to the applicable customary- or prevailing-charge criteria recommended by SSA. If charges did not exceed these limits, claims were paid even if the charges exceeded both customary and prevailing charges for comparable services. For example, Texas Blue Shield established a $100 minimum for surgical procedures; however, charges in excess of $100 had to be within $25 of the customary or prevailing charge. Minimum limits were established of $15 for diagnostic X-rays and $10 for such medical services as office visits; however, if the charge for medical services was greater than $10, the charge had to be within $4 of the customary or prevailing charge to be allowed

The 100 claims included in our sample contained charges for 902 services We could not compare charges for 481 services with customary or prevailing charges because sufficient data on the physicians' charges for some services had not been accumulated. Other services were paid for without obtaining adequate evidence as to the nature or frequency of the services provided, and some were duplicates of services for which payments had already been made. For the remaining 421 services, our comparison of the amounts allowed with the customary and prevailing charge data maintained by Texas Blue Shield showed that 46 charges on 23 claims had exceeded the reasonable charges by a total of $85.60. Examples of amounts allowed in excess of reasonable charges are as follows

Service provided	Established reasonable charge	Allowable under Texas Blue Shield's criteria	Amount allowed (note a)	Amount allowed in excess of established reasonable charge
Surgery	$335.00	$360.00	$350.00	$15.00
Home visit with professional care	11.00	19.00	15.00	4.00
Hospital visits (four)	28.00	40.00	40.00	12.00
Office visits (six)	48.00	60.00	54.00	6.00
Diagnostic X-ray	7.00	15.00	10.00	3.00
Complete physical exam	20.00	24.00	25.00[b]	5.00
Electrocardiogram	10.00	24.00	15.00	5.00
Routine home visit	6.00	10.00	10.00	4.00
Hospital care	25.00	39.00	35.00	10.00
Hospital visit	20.00	24.00	30.00[b]	10.00

[a] In each case, the amount allowed was the same as the physician's actual charge for the particular service provided.

[b] Amount allowed exceeded the amount allowable under Texas Blue Shield's criteria because of an error in determining the reasonable charge.

In September 1966, SSA advised Texas Blue Shield that its method of evaluating the reasonableness of physicians' charges did not comply with applicable laws and regulations. Although SSA made several follow-up inquiries on this matter, Texas Blue Shield continued to use its own method Thus for another 16 months some payments exceeded reasonable charges

In December 1967, we were advised by Texas Blue Shield that a new method of determining reasonable charges that would eliminate the use of preestablished limits would be implemented Early in 1968, Texas Blue Shield discontinued the use of its preestablished limits and began applying the customary- and prevailing-charge criteria, prescribed by SSA, to physicians' charges

Texas Blue Shield's medical director advised us in August 1968 that the number of claims for which reasonable charges had been determined to be less than the amounts billed had increased from about 3 percent of the claims paid before February 1968 to about 12 percent of the claims paid after February 1968 when payments were limited to the lesser of customary or prevailing charges

DUPLICATE PAYMENTS

Our examination of a random sample of 400 claims processed during the 3-month period showed that Texas Blue Shield had made duplicate payments totaling about $402 for 70 medical services on 13 claims. Our review of the 13 claims showed that most of the duplicate payments resulted from coding errors which rendered Texas Blue Shield's duplicate-claim edit procedure ineffective or from the procedure's not providing for an effective cross-check of claims processed on the same day.

Applying the results obtained from our examination of the sample to all claims processed during the 3-month period covered by our review, we estimate that Texas Blue Shield made duplicate payments totaling about $270,000 on about 8,800 claims during that period. If the rate and amounts of duplicate payments made during this 3-month period are indicative of duplicate payments made during the entire year, Texas Blue Shield could have made duplicate payments

totaling about $1 million on about 35,000 claims during calendar year 1967

We noted that Texas Blue Shield used a computerized duplicate-claim edit procedure This procedure involved comparing data on claims in process with similar data on claims paid The data compared included (1) physicians' identification numbers, (2) beneficiaries' health insurance benefit numbers, (3) types of services provided, and (4) dates of services provided We were advised by a Texas Blue Shield official that claims containing data identical to that contained in claims previously paid were rejected by the computer and submitted to a review section for further investigation

We found that, although the above procedure was being followed by Texas Blue Shield, coding errors made by claims examiners (see p. 25) resulted in duplicate payments' being made on 11 of the 13 claims we reviewed. For example, one duplicate payment was made because a claims examiner, in coding the claim for processing, had used the date on which the beneficiary had paid for the service rather than the date on which the service had been provided. As a result of this coding error, Texas Blue Shield's duplicate-claim edit procedure did not detect the duplicate payments.

Duplicate payments were made also because the original claim and the duplicate were processed on the same day Consequently, payment history for the original claim was not yet available for comparison with the duplicate claim being processed Texas Blue Shield advised us that, for periods subsequent to that covered by our review, a computer procedure, which, it believed, should prevent this type of error in the future, had been initiated to cross-check claims processed on the same day

The Assistant Secretary, Comptroller, HEW, advised us in June 1970 that the carrier then had a satisfactory method for detecting duplicate claims. Steps had also been taken to improve the processing of claims by giving additional training to the coding staff and by establishing a quality control system We were advised also by HEW that·

"With respect to the duplicate payments made during past periods, the carrier has been directed to develop a program for identifying the duplicates and to estimate the cost of recovery and the time required to complete recovery."

PAYMENTS MADE WITHOUT OBTAINING ADEQUATE EVIDENCE THAT CHARGES WERE REASONABLE

Our examination of a random sample of 100 claims processed during the 3-month period showed that Texas Blue Shield made payments totaling $1,336.11 for 194 services on 27 claims without obtaining adequate evidence that the amounts charged for the services were reasonable. On the basis of these result, we estimate that, during that 3-month period, Texas Blue Shield paid claims amounting to about $3.7 million without obtaining adequate evidence that the amounts charged for the services were reasonable. Assuming that the payments so made during the 3-month period covered by our review was indicative of such payments made during the entire year, Texas Blue Shield could have paid as much as $15 million during calendar year 1967 without obtaining adequate evidence of the reasonableness of the charges. Our examination did not include a determination of the extent of overpayments which may have resulted from this lack of evidence.

The Social Security Act provides that payments for physicians' services be made on the basis of reasonable charges. SSA instructions provide that the carrier assure itself that medical insurance payments are made only for medically necessary, covered services. We believe that the carrier, to comply with these requirements, would have to know the nature and the frequency of the services rendered by physicians.

Our examination of the random sample of 100 claims showed also that payments for 167 services had been processed without adequate evidence of the nature and the frequency of services provided or that the services were covered under the Medicare program. Some examples of inadequate evidence of the nature and the frequency of services follow:

Claim 1

A physician submitted a claim, dated June 21, 1967, in the amount of $315 for medical care provided to a Medicare beneficiary. Included in the claim were two charges, totaling $210, for inpatient hospital care. One charge of $50 was described as being for medical care in hospital provided

during the period April 10 to 19, 1967. The second charge of $160 was a package charge described as being for incision and drainage of hematoma (tumor on right hip), medical care in hospital, and multiple transfusions provided during the period May 10 to June 12, 1967.

In processing the claim, Texas Blue Shield concluded that the incision and drainage was a minor procedure that did not warrant separate coding. It assumed that the services provided were routine hospital visits and that the physician visited the patient once a day for 32 days. On the basis of the carrier's assumptions, the average charge for these visits was $6.56. We noted that the physician's customary charge for routine hospital visits, as established by the carrier, was $5.

Claim 2

A Medicare beneficiary submitted a claim, dated June 12, 1967, in the amount of $142.80 for various medical services provided to him during the period January through May 1967. Among the services for which payment was requested were four routine office visits at $6 each.

The beneficiary requested payment also for one service, described by the physician only as professional services, in the amount of $7. Because of the amount of the physician's charge, Texas Blue Shield assumed that this service was also a routine office visit and paid the amount without obtaining additional information as to the nature of the service or as to whether the professional services provided were medically necessary and covered under the Medicare program.

We believe that, for both of these claims, Texas Blue Shield should have requested additional information to determine the nature of the services provided and the reasonableness of the charges.

The remaining 27 services involved medical services, other than physicians services, for which Texas Blue Shield had not established a basis for determining the reasonableness of the charges. For example, two claims containing charges for ambulance service for $17.50 and $25,

respectively, were submitted by two beneficiaries and were paid by Texas Blue Shield without a determination of the reasonableness of the charges because it had not compiled charge data for this type of service. Therefore there was no assurance that the amounts paid were reasonable in relation to the services provided.

Our findings on these 27 services were discussed with the medical director of Texas Blue Shield in July 1968. He advised us that reasonable-charge information was being compiled for such medical services as ambulance service and prosthetic devices and that, when sufficient data had been compiled, claims for such services would be subjected to a reasonable-charge determination. Until that time, such claims were to be paid on the basis of subjective determinations made by Texas Blue Shield.

Emergency claims processing procedures

Because of a nationwide backlog of unpaid Medicare claims, SSA instituted temporary, emergency claims-processing procedures in fiscal year 1967. These procedures were designed to expedite the payment of claims. SSA was particularly concerned at the time with the number of claims which were being returned to the physician or beneficiary or which were being delayed because they had not completed the claim forms or had not furnished adequate data to support the claims.

The emergency procedures were established initially for claims covering services provided prior to April 1, 1967, and were subsequently extended to include claims for services provided through the latter part of calendar year 1967. The procedures provide, in part, that

1. A claim may be processed if the description of the illness or injury or the place where the services were received is missing or incomplete, provided that this information can reasonably be inferred from other information on the claim, the bill, prior claims, or other information available to the carrier.

2. In the absence of indications to the contrary, the carrier may assume that the services for which a

claim is made are covered services and that the illness or injury was not work related.

3. The carrier may make payment on the basis of a receipted bill only if the enrollee is clearly identified, there is sufficient information on the bill for a reasonable-charge determination, and the services appear to be connected with the same illness for which a claim was previously filed.

Texas Blue Shield officials advised us that the emergency claims-processing procedures permitted them to make assumptions relating to types and frequency of services provided. We recognize that the emergency procedures authorized Texas Blue Shield to make payments under certain circumstances without obtaining information in addition to that provided in support of the claim. We believe, however, that the circumstances involved in most of the claims paid without adequate evidence that the charges were reasonable were not of the types covered by the emergency procedures. On the basis of our analysis of the 194 services for which payments had been made without adequate evidence that the charges for the services were reasonable, we concluded that about 16 percent of the payments could have been justified under the emergency procedures. We believe also that the remaining 84 percent of the payments should have been questioned by Texas Blue Shield and that more information should have been obtained about the types and frequency of services performed to determine whether the amounts charged for these services were reasonable.

In July 1968, SSA revised its regulations and informed the carriers that certain assumptions could be made regarding the type and extent of evidence needed to support claims. The revised regulations state, in part, that, if a claim for services rendered does not clearly specify the nature and frequency of the services or if there is any question whether the same type of service was rendered in each instance, the carrier, to resolve the question, should either obtain this information or use its judgment and knowledge of the practices of the physician or supplier in charging fees.

The revised regulations cited an example in which a claim may be submitted showing July 10 to 20 as the period during which medical care was rendered and a charge of $95 for visits made by a physician to a hospital inpatient. Assuming that the physician visited the patient once a day for 11 days, the average charge for each visit would be $8.63. This would be an indication that the physician had not visited the patient 11 times during the 11-day period, that the charges and services rendered during the period were not identical, or that the physician had made a package charge for the period of treatment rather than an individual charge for each service. The carriers were advised to resolve such problems by either (1) consulting with the patient or the physician or (2) exercising their judgment as to whether the physician had made a package charge or whether the $95 charge was for one visit at $15 and 10 visits at $8 each. Then, if the assumed amounts satisfy the customary and prevailing charge criteria, the carrier may determine that the charges were reasonable.

The Social Security Act provides that payments to physicians be made on the basis of reasonable charges. We believe that, to determine the reasonableness of charges, a carrier should be required to obtain sufficient information to establish the nature and frequency of the services provided. In our opinion, the latitude of judgment which a carrier may exercise under existing regulations precludes assurance that charges are reasonable for many of the services rendered. Furthermore, any erroneous data recorded in the physicians' customary-charge profiles as a result of inadequate information could adversely affect future determinations of reasonable charges.

In June 1970, the Assistant Secretary, Comptroller, HEW, in commenting on our finding, stated that the July 1968 revision to SSA's Medicare regulations was intended to avoid unnecessary checks of hospital records or consultations with physicians when information needed to properly process claims could be obtained some other way. He advised us also that:

> "We have already determined that more work needs to be done where carrier judgment is permitted in making reasonable charge determinations for

package charges, per diem charges ***, and combined charges for services rendered during an inclusive period. In addition, where carriers use judgment, they have not always properly documented their records to show the basis for their determination.

"We have already asked carriers to pinpoint charges for services actually rendered as opposed to merely accepting global fees for inpatient hospital visits. *** BHI [Bureau of Health Insurance, Social Security Administration] is now developing a manual instruction on verifying charges for actual visits shown on a claim, and for verifying the frequency of visits in per diem charge claims where the carrier has reason to suspect that visits were not made frequently enough to support the per diem charge."

Furthermore, we have been advised by HEW that, to prevent paying claims without proper documentation, Texas Blue Shield now requires identification of all services prior to paying the claims.

ERRORS IN CODING AND RECORDING CUSTOMARY-CHARGE DATA

In our review of the sample of 100 claims, we found errors in the coding or recording of essential data relating to 56 services on 19 claims. Payments to physicians are required to be made on the basis of reasonable charges as determined by the carrier. The Social Security Act provides that, in determining reasonable charges, the carrier consider customary charges made by the physician for his services. The carrier develops for each physician a customary-charge profile by recording his charges for like services rendered in the past. These charges include those for services rendered to persons insured under private insurance and under other Government insurance programs. The carrier then determines the amount the physician most frequently charges for each specific service.

Although, with one exception, the errors we noted in our review of the sample of 100 claims did not affect the amount of payment, the coding errors we noted in the 400 claims we reviewed to detect duplicate payments (see p. 16) did result in duplicate payments. In addition, these coding errors may have resulted in a distortion of the physicians' customary charges as maintained in the profiles which are used as a basis for determining reasonable charges. Further, we believe that these errors, when considered with the other errors which resulted in duplicate payments as discussed previously, indicate a need for Texas Blue Shield to institute quality-control measures in its claims-processing procedure to reduce the incidence of errors.

We found also that Texas Blue Shield evaluated the work of its claims examiners on the basis of the number of claims processed and that the quality of their work was generally not subjected to formal review. We found further that Texas Blue Shield's system for reviewing Medicare claims did not include a quality check or postaudit. After we completed our review, officials of Texas Blue Shield advised us that the work of claim examiners would be evaluated on the basis of the quality, as well as the quantity, of the Medicare claims processed.

NEED TO STRENGTHEN PROCEDURES TO MINIMIZE PAYMENTS FOR UNNECESSARY SERVICES

At the time of our review, Texas Blue Shield had a system for identifying physicians who might have provided unnecessary services. We were advised by the medical director of Texas Blue Shield, however, that it did not have specific procedures for investigating the physicians who the system indicated might be providing unnecessary services. He advised us also that a few claims for unnecessary services had been noted by the claims examination section and that claims filed by certain physicians had been placed under special observation. As mentioned previously, Texas Blue Shield's contract with the Secretary of HEW required Texas Blue Shield to assist in the application of safeguards against unnecessary medical services.

The system established by Texas Blue Shield to identify physicians whose patterns of charges and services are unusual provides for comparing certain information regarding physicians' services and charges with predetermined norms. The system also calls for the preparation of a report listing the names of those physicians whose charges and/or services exceed the norms.

For comparative-analysis purposes, eight different norms were established as follows: (1) number of charges per month, (2) amount of charges per month, (3) amount per patient per month, (4) number of patients per month, (5) number of charges per patient, (6) amount per charge per patient, (7) amount of charges for 6 months, and (8) number of charges for 6 months. The claims data, as submitted by physicians, is compared with the norms, and a listing is prepared that identifies those physicians whose services or charges exceeded any one of the predetermined norms for at least 4 different months during the 6-month period covered by the report.

In October 1967, Texas Blue Shield, using data accumulated from the beginning of the program to about March 1967, prepared a report which named 590 physicians (about 5 percent of all physicians) and other suppliers in Texas who had submitted Medicare claims during this period and whose services or charges exceeded the established norms.

At the time of our review, however, no action had been taken to determine whether medical services had been rendered unnecessarily or whether other irregularities existed in the cases in which the norms had been exceeded. In March 1968, the medical director of Texas Blue Shield advised us that no routine follow-up procedure for investigation of questionable claims or other irregularities had been established.

We obtained a copy of Texas Blue Shield's report (listing of physicians whose services or charges exceed the norms) and selected from the report 50 physicians, to determine whether unnecessary medical services had been rendered The report showed that 42 of the physicians had exceeded more than one norm, as follows·

Number of physicians	Number of norms exceeded
1	4
21	3
20	2
8	1

On the basis of our review of the information available from Texas Blue Shield, we could not establish conclusively whether any medical services had been rendered unnecessarily. We noted, however, unusual patterns of service by some physicians, which, we believe, might involve unnecessary services. Some examples of these patterns of service follow.

Physician A

This physician submitted claims for daily hospital visits to several of his patients for periods from 12 to 23 consecutive months ended with May 1968, as follows

Patient	Number of consecutive months during which daily visits were claimed	Total number of visits	Total charges for visits
A	23	699	$3,495
B	23	699	3,495
C	23	699	3,495
D	23	699	3,495
E	23	700	3,500
F	14	427	2,135
G	12	366	1,830

All the patients were in the same hospital, except patient F who was confined in a hospital located about 63 miles away The Texas Blue Shield report showed that this physician had made 4,056 Medicare charges, totaling about $21,987, for 129 patients during the 8-month period covered by the report.

Physician B

This physician appeared to be performing an unusual number of laboratory examinations. Further, it appeared that husbands and wives were receiving almost identical examinations. For example, one such couple was provided with the following services during an 11-month period at a total cost of $731. Further, for 2 consecutive months, August and September 1967, they received the same services on the same day.

	Office visits		Injections		Laboratory examination		Electrocardiogram		Chest X-rays	
1967	H	W	H	W	H	W	H	W	H	W
Jan.	-	-	-	-	3	4	1	1	1	1
Feb.	-	-	-	-	3	3	1	-	1	1
Apr.	1	-	-	1	4	4	1	1	1	1
June	1	1	1	1	6	5	1	1	1	1
Aug.	1	1	1	1	4	4	1	1	1	1
Sept.	1	1	1	1	4	4	1	1	1	1
Nov.	1	1	1	1	6	3	-	1	1	1
Total	5	4	4	5	30	27	6	6	7	7

Notes.
H--Husband
W--Wife

Physician C

This physician charged 10 nursing-home patients a total of $450 for weekly visits during the months of September and October 1967. Another patient was charged $120 for daily nursing-home visits during October 1967. During the 8-month period covered by the report, this physician made 2,744 Medicare charges, totaling about $14,734, for 112 patients. The medical director of Texas Blue Shield advised us that the normal practice was to visit nursing-home patients monthly.

Our findings were discussed with the medical director of Texas Blue Shield in August 1968, at which time he stated that the three cases cited above would be investigated. He advised us that some physicians had been investigated because claims examiners had questioned the nature of their charges and that some of the physicians' claims had been turned over to SSA. We were advised that a second report, listing the names of those physicians whose services or charges exceeded predetermined norms, would be prepared, at which time Texas Blue Shield's procedures for the identification and control of unnecessary medical services would be formalized.

On September 30, 1968, we met again with Texas Blue Shield's medical director to discuss the status of its procedures for identifying and controlling unnecessary services and its investigations of the three cases previously discussed in this report. He advised us that each physician associated with those cases had been consulted and that these physicians would take a closer look, in the future, at the medical necessity of the services to be provided. Further, one physician (physician A above) had found a mistake in billing for one of his patients (patient F above) and agreed to refund the amount ($2,135) paid on behalf of that patient. The medical director advised us also that his staff would make follow-up inquiries on these three cases. He advised us further that the procedures for identifying unnecessary services had not been fully implemented but soon would be.

In June 1970, we were advised by an HEW official that Texas Blue Shield was employing a system of postpayment electronic data processing (EDP) utilization screens to detect unnecessary medical services and expected to employ prepayment screens within a relatively short time.

AGENCY COMMENTS AND GAO EVALUATION

In June 1970, the Assistant Secretary, Comptroller, HEW, advised us that, after the period covered by our review, Texas Blue Shield had revised its claims-processing procedures and had taken some steps to correct or minimize the deficiencies noted during our review He also stated that SSA had taken many actions to improve claims processing and administration of the supplementary medical insurance program by all carriers

The Assistant Secretary, Comptroller, stated that SSA had been continually assessing and seeking ways to improve the effectiveness of its surveillance activities Onsite SSA representatives have been placed at all the larger carriers to study all facets of the carriers' claims-processing activities, and SSA plans to place an additional onsite representative at Texas Blue Shield to work solely on part B activities Also, systems technicians are being placed in each SSA regional office to assist in evaluating claims and data processing systems, as well as any changes to the data processing systems that may be contemplated.

We were advised that the duplicate-payment problem was not peculiar to Texas Blue Shield but that the problem had been brought under control Carriers have made systems improvements to conform with SSA specifications and have refined their duplicate-claims detection screens and procedures Other carriers have installed the computerized claim-processing system (part B model system) developed by SSA

We were advised by the Assistant Secretary that, to ensure that all carriers had effective controls to minimize payments for unnecessary medical services, SSA issued instructions in February 1970 that set out specific minimum prepayment and postpayment controls which must be built into each carrier's control system. Also, SSA has been moving to ensure that carriers obtain adequate information on the nature and frequency of services before program payments are made and is reviewing and reassessing its instructions to make sure they do not leave undue room for carrier interpretation

We recognize that since 1967 Texas Blue Shield has revised its claims-processing procedures and has taken steps to minimize or prevent the payments of Medicare claims in amounts that exceed those which it had determined to be reasonable for the services provided. Texas Blue Shield has taken steps also to reduce duplicate payments and payments for unnecessary medical services. Nevertheless a review of Texas Blue Shield activities which SSA completed in October 1969 showed that, subsequent to the implementation of the revised claims-processing procedures, certain problems still existed. adequate determinations of the reasonableness of charges for certain types of medical services were not being made, duplicate payments were still being made, and an effective method of minimizing payments for unnecessary medical services had not yet been implemented.

We recognize also that other carriers and SSA have taken steps which should minimize or prevent some of the claims-processing problems noted during our review According to SSA records, however, some other carriers, as of April 1970, were still not making the reasonable-charge determinations required by SSA criteria even though they had been participating in the Medicare program from its inception in June 1966 SSA records show that as of April 1970 some other carriers had not instituted appropriate safeguards against payments for unnecessary medical services, even though the program had been in effect over 4 years SSA's contract performance review teams are still noting coding and recording errors in their routine reviews of the carriers' claims-processing activities

Therefore it appears that some of the problems noted during our review still persist at some carriers and that some effort is needed on the part of both the carriers and SSA to further improve claims-processing activities under the supplementary medical insurance program.

CARRIER'S COMMENTS

Comments on the matters discussed in our report were requested from Texas Blue Shield in February 1970, but as of October 30, 1970, we had not received any written comments from the carrier

In March 1970, we met with Texas Blue Shield officials to discuss our findings and to explain the basis for our conclusions. At that time Texas Blue Shield officials disagreed with the statistical methods we used and questioned the validity of audit findings derived from our statistical sample.

Texas Blue Shield was subsequently furnished with detailed information as to the statistical methods we used in selecting and validating the sample of claims reviewed and as to the basis we used for arriving at the dollar estimates in our report. We met with Texas Blue Shield officials again in April 1970 and further explained our sampling and estimating methods.

In view of the amount of time that has passed since our discussions with Texas Blue Shield officials, we concluded that it did not wish to make any formal comments concerning our findings, conclusions, and recommendations.

CONCLUSIONS

We believe that there is a need for more effective surveillance by HEW of carriers' claims-processing activities. Although prior to the completion of our review HEW auditors and SSA contract performance review teams had made reviews of Texas Blue Shield's activities, our review indicated that improvements were needed in the carrier's claims-processing activities. Subsequent to the completion of our review, SSA made a second contract performance review at Texas Blue Shield and reported that as of October 1969 there was a need for further improvements in the carrier's claims-processing activities, particularly with respect to detecting and preventing duplicate payments and payments for unnecessary medical services.

We believe also that such audits and contract performance reviews and related reports can help improve administration of the Medicare program but that such reviews should not be considered substitutes for sound management practices necessary to ensure that the carriers are discharging their responsibilities in accordance with applicable law and regulations.

Various committees and members of the Congress have expressed concern over the rising costs of medical care under the Medicare program. We believe that, through more effective surveillance of the claims-processing activities of carriers under part B of the Medicare program, HEW could make a significant contribution toward minimizing unwarranted payments and thereby help keep Medicare costs to the minimum necessary for effective and efficient administration of the program.

Although the deficiencies in claims-processing activities noted during our review related only to the activities of Texas Blue Shield, we believe that similar deficiencies may exist at other carriers

We believe further that the effectiveness of the management of the Medicare program would be significantly improved and that the cost of the program could be reduced if, in the future, prompt and effective corrective actions were to be taken concerning known deficiencies whether disclosed by HEW audits, SSA contract performance reviews, or other means Therefore we believe that HEW should undertake closer and more effective surveillance of carriers' claims-processing activities with the objectives of timely disclosure of significant deficiencies and the initiation of prompt and effective corrective action.

Although the carrier and SSA have taken, or have agreed to take, corrective action with respect to the deficiencies we noted, we believe that HEW should evaluate the effectiveness of the corrective action taken or promised.

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that the Secretary of Health, Education, and Welfare take appropriate measures to provide for

--more effective surveillance by SSA of carriers' claims-processing activities;

--an evaluation by SSA of the effectiveness of the corrective action taken or planned by Texas Blue Shield to improve claims processing, detect duplicate claims, and minimize payments for unnecessary medical services; and

--a review and evaluation of SSA's current regulations which allow carriers to make certain assumptions concerning the nature and extent of services provided, to determine how much latitude the carriers should have in determining the reasonableness of charges.

CHAPTER 4

NEED TO STRENGTHEN CONTROLS OVER CARRIERS' SUBCONTRACTING ACTIVITIES

We believe that there is a need for SSA to strengthen its controls over the subcontracting activities of its carriers, to minimize the possibilities of the carriers' entering into contractual arrangements which may result in excessive costs to the Medicare program.

Texas Blue Shield subcontracted for the performance of a substantial portion of its Medicare claims-processing activities without obtaining prior approval from the Secretary of HEW. Also, Texas Blue Shield did not provide for the Secretary and GAO to have access to, and the right to examine, the subcontractor's cost records, contrary to its contract with the Secretary of HEW. The fact that Texas Blue Shield had not fully complied with the provisions of its contract with the Secretary of HEW was brought to the attention of SSA officials by an HEW Audit Agency report issued in October 1967.

As a result, SSA was committed to make payments which could have amounted to as much as $6 million during the 4-1/2-year period covered by the subcontracts without having contractual authority to enable it to review the subcontractor's pertinent cost records to determine the reasonableness of the subcontractor's charges. Because the subcontract did not provide for GAO to have access to the subcontractor's cost records and because the subcontractor would not give GAO access to its records voluntarily, we could not evaluate the propriety and reasonableness of the subcontractor's charges to the Medicare program. The HEW Audit Agency, in its efforts to review and evaluate the reasonableness of Texas Blue Shield's administrative costs, was also denied access to the subcontractor's pertinent cost records.

Furthermore, included in the possible payments of $6 million was $250,000 which SSA was committed to pay to the subcontractor for the development of a computer program and system of EDP procedures for processing medical claims

at Texas Blue Shield. Because title to the program and system was vested in the subcontractor, the program and system cannot be made available for use without the subcontractor's permission or without cost to other carriers to achieve savings in developing their computer programs.

We believe that the disputes clause included in Texas Blue Shield's contract with the Secretary of HEW does not provide SSA with an adequate means for determining how much the carrier should be reimbursed for its services, or the services of subcontractors, in situations where the carrier has not fully complied with the provisions of its contract.

The current contracts between the Secretary of HEW and the carriers provide, in part, that:

> "If the Secretary and the carrier are unable to agree upon a final determination of the administrative cost of the Carrier for a particular period, the Secretary shall determine such administrative costs for such period and inform the Carrier ***".

The Secretary's determination of costs is subject to appeal by the carrier. This contract provision is similar to the standard disputes clause, generally included in Government contracts, whereby disputed issues of facts arising under the contract are unilaterally decided by the contracting officer subject to the contractor's right to appeal to the agency head, except that it is limited to disagreements over the final determinations of Medicare administrative costs.

Our findings are discussed in greater detail in the following sections of this chapter.

SUBCONTRACTING BY CARRIER FOR DATA PROCESSING SERVICES

Texas Blue Shield's contract with the Secretary of HEW provides, in part, that the carrier not enter into subcontracts for any of its functions under the contract or into fixed-price purchase orders in amounts over $25,000 unless approved by the Secretary. The contract provides also that

all such subcontracts include an access-to-records clause which gives the Secretary of HEW and the Comptroller General of the United States access to, and the right to examine, pertinent books and records of the subcontractors involving transactions related to the subcontracts

During the period June 1966 through January 1968, Texas Blue Shield entered into a series of subcontracts with Electronic Data Systems Corporation (EDS) for furnishing data processing services to Texas Blue Shield for its Medicare program activities and for its commercial business.

The last of these subcontracts, which was awarded in January 1968, covered all the data processing services being furnished by EDS to Texas Blue Shield. Under this subcontract, EDS was responsible for performing a significant portion of the Medicare claims-processing functions of Texas Blue Shield.

Texas Blue Shield had not obtained the Secretary of HEW's approval of these subcontracts, although such approval was required by its contract with the Secretary. Also, none of the subcontracts contained the required access-to-records clause. The HEW Audit Agency, in its report to SSA dated October 1967, stated that, because access to the subcontractor's records was limited and because no written records of the contract negotiations were available, it had been unable to determine the reasonableness of the cost of the services provided by EDS.

In November 1967, SSA proposed to Texas Blue Shield that it (1) draft a subcontract for the needed data processing services and furnish a copy to SSA, (2) obtain cost proposals from several data processing firms after SSA agreed to the terms of the subcontract, (3) submit the firms' proposals to SSA with a recommendation as to which firm should be selected and why, and (4) negotiate in good faith with SSA the amount which SSA would pay for the EDS services provided from the beginning of the program through December 1967. SSA's proposal, which was made prior to the award of the January 1968 subcontract by Texas Blue Shield, was the beginning of extensive discussions and negotiations--which

continued for over 2 years--between SSA and Texas Blue Shield to resolve their differences concerning the carrier's subcontracts with EDS.

During this period, SSA maintained that (1) prior approval of the subcontracts was required, (2) the cost of the EDS services greatly exceeded the cost of comparable work performed by other carriers, and (3) Texas Blue Shield should be reimbursed only for the reasonable value of the services provided During the same period, Texas Blue Shield maintained that prior approval of the EDS contracts was not mandatory since the agreements were not primarily for Medicare work and that it should be reimbursed the full amount of the subcontract price related to its Medicare work

The medical director, Texas Blue Shield, advised us in November 1968 that Texas Blue Shield had assumed that the requirement that an access-to-records clause be included in each subcontract applied only when prior approval of the subcontract also was required Texas Blue Shield since it believed that the EDS subcontracts did not require prior approval by SSA, had concluded that the access-to-records clause was not necessary

We believe it is significant to point out that Texas Blue Shield, although SSA had instructed it in November 1967 that prior approval of subcontracts for EDP services was required, had negotiated and awarded a new subcontract to EDS, effective January 1968, which provided for the transfer of total responsibility for its data processing activities to EDS The new subcontract was not submitted to HEW for approval and did not include the required access to records clause

Also, in February 1968 SSA advised Texas Blue Shield that the computer program and the system of EDP procedures developed by EDS to process Medicare claims should become the property of the Federal Government, since the cost of development was borne by the Government The cost of this work performed by EDS amounted to about $250,000 SSA was advised in March 1968 by Texas Blue Shield that it did not agree that the Government should receive title SSA was not advised by Texas Blue Shield, however, that the January 1968 subcontract with EDS provided that the title to the computer

program and system of EDP procedures be vested in EDS. As a result, SSA cannot make the computer program that was developed with Medicare funds available for use without the permission of EDS or without cost to other carriers to achieve savings in their computer program development costs

SSA ACTION TO RESOLVE PROBLEMS RELATING TO CARRIER'S SUBCONTRACTS FOR DATA PROCESSING SERVICES

After several unsuccessful attempts to obtain cost data from EDS for use in determining actual costs relating to the EDS subcontract, SSA decided to reimburse Texas Blue Shield on a quantum meruit basis (a reasonable value for the services provided) for the services obtained from EDS. SSA concluded that the best evidence of reasonable value would be the amount paid by other carriers for comparable services

Early in 1969, SSA compared the amount EDS was charging Texas Blue Shield for data processing services with the amount Electronic Data Systems Federal Corporation (a wholly owned subsidiary of EDS) was charging Pennsylvania Blue Shield for similar services. On the basis of its comparison, SSA concluded that the maximum amount which Texas Blue Shield should be paid was $0.706 for each claim processed.

Also, in 1969 the California Physicians' Service, another Medicare carrier, entered into a contract with EDS Federal Corporation for data processing services similar to those being provided in Pennsylvania and Texas by the corporation. This contract provided that, for processing a volume of claims comparable to that processed in Pennsylvania and Texas, the corporation would be paid about $0.66 for each claim processed, which appears to be in line with the amount SSA proposed to pay Texas Blue Shield. The California and Pennsylvania contracts were submitted to SSA for approval, and both contracts have appropriate access-to-records clauses.

In June 1969, SSA advised Texas Blue Shield that it would be paid at the rate of $0.706 for each claim for costs incurred under the EDS subcontract for the 18-month period January 1, 1968, to June 30, 1969. SSA advised Texas Blue Shield also that SSA could not agree to the continuation of the existing subcontract with EDS, that it was understood that a new subcontract was being drafted for SSA's approval; and that, if the proposed settlement was unacceptable, the issue should be submitted to the Armed Services Board of

Contract Appeals which has been designated by the Secretary of HEW to hear and determine contract appeals.

Texas Blue Shield then advised SSA that it would appeal the decision regarding the rate of payment and that discussions were under way with the Undersecretary of HEW, which Texas Blue Shield hoped would lead to a reconsideration of this matter.

Carrier to be reimbursed full contract price

In October 1969, SSA changed its earlier decision regarding the rate of payment and advised Texas Blue Shield that it would be paid at the rate of $0.855 for each claim processed, as stipulated in the EDS subcontract. This decision will result in SSA's paying about $585,000 in excess of the amount which it would have paid on the basis of $0.706 for each claim, for the services provided by EDS.

In December 1969, SSA officials informed us that, after Texas Blue Shield had given notice of its intent to appeal SSA's decision, SSA had reviewed the entire record concerning the amounts claimed by Texas Blue Shield for EDS services, including its performance record and its total claims-processing costs compared with those of other carriers. These officials informed us also that SSA had concluded that the amounts claimed were not unreasonable and had decided to pay for the services at the full rate provided for in the subcontract.

SSA's determination of the amount which would be paid to Texas Blue Shield, however, did not involve an examination into the costs incurred by EDS Federal Corporation in providing computer services to the other carriers where they had the right of access to the cost records. Therefore we have some doubt as to whether SSA should have agreed to pay the full cost specified in the Texas Blue Shield contract with EDS.

In August 1970, SSA officials advised us that Texas Blue Shield had entered into a new subcontract with EDS, which provided for an average payment rate of about $0.75 for each claim processed and that the subcontract had been approved by SSA in March 1970. We were advised also that

the new subcontract contained the appropriate access-to-records clause.

AGENCY COMMENTS AND GAO EVALUATION

In response to our suggestion that SSA strengthen its controls over the subcontracting activities of its carriers by clarifying the circumstances under which prior approval of subcontracts is mandatory, the Assistant Secretary, Comptroller, HEW, advised us in June 1970 that SSA was negotiating revisions to the applicable provisions of its contracts with the carriers. He stated that the revisions would require the carriers to submit for review and approval subcontracts involving a major function or substantial Medicare funds, particularly those involving EDP, audit, or management consultation.

We were advised also that SSA had issued instructions in November 1969 requiring carriers wishing to contract for part B EDP systems to prepare specifications and to secure written proposals from the firms which are able to supply a suitable system and the type of services needed.

CONCLUSIONS

We believe that SSA should further strengthen its controls over the subcontracting activities of its carriers by broadening the scope of the disputes clause, which is currently made a part of each carrier's contract, to cover all other areas of disputes, except for directives and regulations governing the administration of the program and contract terminations which are specifically covered by other provisions in the contracts. Such a clause would provide SSA's contracting officer with an administrative procedure, which he does not now have, for the settlement of disputes arising under the contracts.

The current disputes clause included in the carriers' contracts with the Secretary of HEW provides only for the settlements of disagreements over the final determination of administrative costs. The clause does not, in our opinion, provide SSA with an adequate means for determining how much carriers should be reimbursed in situations where they

have not complied with the provisions of their contracts with the Secretary of HEW.

In August 1970, we discussed with officials of the HEW General Counsel's Office the merits of broadening the carrier-contract-disputes clause to cover all disputes of fact arising under the contracts. Although these officials did not agree to the use of the standard disputes clause, they did agree to consider the desirability of expanding the language of the current clause to include disputes over other issues of fact arising under the contracts. Furthermore, they indicated that directives, instructions, and regulations issued by the Secretary of HEW for the administration of the Medicare program should be specifically excluded from consideration under the disputes clause, because this exclusion would prevent the carriers questioning and otherwise challenging these directives and instructions.

RECOMMENDATIONS TO THE SECRETARY OF HEW

We recommend that the Secretary of Health, Education, and Welfare take appropriate action to provide for further strengthening of HEW's controls over the subcontracting activities of carriers by

--clarifying the circumstances under which prior approval by SSA is required for subcontracts awarded by its Medicare carriers and

--broadening the disputes clause in the carriers' contracts with HEW to cover all disputes except matters relating to the Secretary's directives and regulations governing administration of the Medicare program and termination of the contracts.

CHAPTER 5

SCOPE OF REVIEW

Our review was made at the SSA Central Office in Baltimore, Maryland; the SSA Regional Office in Dallas, Texas, and at Texas Blue Shield, Dallas, Texas. Our review was concerned principally with the manner in which Texas Blue Shield processed claims for supplementary medical insurance benefits, except for certain types of claims for services rendered by hospital-based physicians, and with its procedures designed to minimize payments for unnecessary medical services. Our review was concerned also with the carrier's contractual arrangements for data processing services and the reasonableness of the charges for these services. We did not review other aspects of the administration of the Medicare program by SSA or Texas Blue Shield.

To evaluate the propriety and accuracy of claims processed by the carrier, we used generally accepted statistical methods to select a random sample of the 274,400 claims processed during September, October, and November 1967. Our sample consisted of 400 claims, all of which we examined for evidence of duplicate payments and 100 of which we examined in detail for propriety and accuracy of payments.

APPENDIXES

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
WASHINGTON

OFFICE OF
THE SECRETARY

JUN 22 1970

Mr. Philip Charam
Associate Director, Civil Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Charam·

Enclosed are the Department's comments on GAO's draft audit report entitled, "Administration of Supplementary Medical Insurance Benefits Under the Medicare Program in the State of Texas."

Initially, you asked that we solicit comments from Texas Blue Shield and that we evaluate these comments before furnishing our own views. Subsequent to our request to Blue Shield, a meeting was held in Dallas, which was attended by GAO representatives At this meeting, the carrier indicated disagreement with GAO's statistical methodology and questioned the validity of audit findings derived from the statistical samples. The carrier has now advised us it cannot furnish written comments in time to meet the target date established by GAO because of the extent of work necessary to resolve the facts, including the need to recall claims in question from the Federal Records Center for reexamination.

In accordance with discussions with Mr. Rother of your staff, therefore, we have gone ahead and prepared our reply without having received formal comments from Blue Shield. The enclosure gives the Department's position on the specific recommendations in your report.

Sincerely yours,

James F. Kelly
Assistant Secretary, Comptroller

Enclosure

ADMINISTRATION OF SUPPLEMENTARY MEDICAL INSURANCE BENEFITS
UNDER THE MEDICARE PROGRAM IN THE STATE OF TEXAS
(GAO Draft Report Transmitted February 16, 1970)

The audit findings are derived from small samples of claims approved for payment by Texas Blue Shield two and one-half years ago (during September, October, and November 1967). Because of this long lapse of time, the recommendations are not entirely relevant or meaningful in terms of current conditions Since 1967, Texas Blue Shield has revised its entire claims processing procedures. In addition, the Social Security Administration (SSA) has taken many actions to improve claims processing and administration of supplementary medical insurance benefits among all carriers. Our comments on the individual recommendations follow

1. Secure more effective surveillance of the carriers' claims processing activities

SSA has been continually assessing the effectiveness of its surveillance activities and seeking ways to make them more effective As an outgrowth of this continuing evaluation, we have placed onsite representatives at all of the larger carriers and intermediaries. At present, the representative at Texas Blue Cross-Blue Shield is responsible for the day-to-day surveillance of the total program, including both Part A and Part B activities. In order to further strengthen this activity, we plan to place an additional onsite representative at Texas so there will be one man giving sole attention to Part B activities

It is the responsibility of the onsite representative to study in depth all facets of the carrier's claims processing activities. This is accomplished through case review at various stages of the process as well as interviewing personnel, evaluating training guides and oral directions given to personnel, and analyzing procedures and policies to ensure that the process is being effectively managed and that SSA directives are followed

In addition, a systems technician is being placed in each Bureau of Health Insurance (BHI) regional office. These technicians will assist onsite representatives and other regional office staff in evaluating on an ongoing basis carriers' claims and data processing systems, as well as any changes that may be contemplated.

The above techniques for the surveillance of carrier activities are in addition to contract performance reviews by specially trained SSA teams, audits by the HEW Audit Agency, the use of operating pars, quantitative standards, and required periodic reports from carriers to measure performance, introduction of test claims into carrier systems, and other surveillance measures.

2 Evaluate the effectiveness of the corrective action taken or planned by the carrier to improve claims processing

To prevent payments of claims in excess of reasonable charges, the carrier has eliminated tolerances in making reasonable charge determinations It has also given additional training to the coding staff, which enters into the processing system the basic data on which reasonable charge determinations are made, and has set up a quality control system

To prevent paying claims without proper documentation, the carrier now requires identification of all services prior to payment For example, the payment for questionable vitamin B-12 injections has been eliminated through proper identification

3 Evaluate the effectiveness of the corrective action taken or planned by the carrier to detect duplicate claims

Generally, we feel that the carrier now has a satisfactory method for duplicate claim detection The Texas Blue Shield duplicate claim detection EDP screen consists of claim number, date of service, supplier/doctor number, and type of service Any claim for services failing these edits is identified as a possible duplicate and routed to a specialized group in the Suspense and Reentry Unit for a clerical examination and a positive determination of whether it is a duplicate As a part of this process, the computer identifies the other claims suspected as being involved in the duplicate As indicated above, steps also have been taken to control coding errors, thus minimizing the chance of duplicates passing undetected

With respect to the duplicate payments made during past periods, the carrier has been directed to develop a program for identifying the duplicates and to estimate the cost of recovery and the time required to complete recovery

The duplicate payment problem was not peculiar to Texas Blue Shield In 1966 and 1967, the first years of operation for the Medicare program, this was identified by SSA as one of the initial problems at other carriers as well Some duplicate claims are inherent in administration of the medical insurance program because of the provision that a claim may be filed by either the patient or his physician. However, the problem of duplicate payment of such claims has been brought under control Carriers have made systems improvements to conform to our specifications, duplicate detection screens and procedures have been refined Other carriers have installed the Part B Model System that was developed by SSA

4. Evaluate the effectiveness of the corrective action taken or planned by the carrier to minimize unnecessary utilization of medical services

Texas Blue Shield is now employing a system of postpayment EDP utilization screens and expects to have prepayment screens within a relatively short period of time. The postpayment screens identify physicians who exceed established parameters. These parameters relate to such items as an unusual incidence of performance of particular procedures, of services per patient, of total payment per patient, and of total medical reimbursement. The screens also identify instances where a questionable number of different physicians bill for services to a particular beneficiary in a quarter. Billings identified by these screens are subjected to special scrutiny to ensure that medical services are not being unnecessarily utilized. The agency also has improved its guidelines and training for claims processors.

To ensure that all carriers have effective controls to prevent overutilization of medical services, BHI issued instructions (Part B Intermediary Letter 70-5) that set out specific prepayment and postpayment controls which must be built into each carrier's system as a bare minimum. Carriers were required to report on the status of any action needed to assure that effective utilization safeguards are part of their ongoing claims process.

5 Evaluate the latitude that should be allowed to carriers in making reasonable charge determinations

SSA has been moving, as recommended, to ensure that carriers obtain adequate information on the nature and frequency of services before they make program payments.

Section 6712.4 of the Part B Intermediary Manual provides in effect that to determine reasonable charges the carrier must know the relevant factors, such as the nature and number of services rendered However, it also provides that "Where the claim does not clearly specify the nature and frequency of the services rendered, or where there is any question about whether the same service was rendered each time, the carrier should either obtain this information or use its judgment and general knowledge of the fee charging practices of the physician . . to resolve the question. In either case, the carrier must be able to document what information was obtained and/or what its judgment was." This provision was intended to avoid unnecessary checks of hospital records or contacts with the physician when information needed to properly process a claim can be established in some other way. An additional consideration was that requiring physicians to list specific services to each inpatient could lead to a fragmentation of their package charges, and thus to an increase in program costs.

We think any problem with regard to Section 6712.4 is not so much related to the intent or substance of the instruction itself, as to the need to make sure it is properly applied To ensure this, BHI is reviewing and reassessing all of its instructions to make sure they do not leave undue room for carrier "interpretation."

We have already determined that more work needs to be done where carrier judgment is permitted in making reasonable charge determinations for package charges, per diem charges (made whether or not services were rendered on any given day), and combined charges for services rendered during an inclusive period. In addition, where carriers use judgment, they have not always properly documented their records to show the basis for their determinations

We have already asked carriers to pinpoint charges for services actually rendered as opposed to merely accepting global fees for inpatient hospital visits. As this specifically concerns teaching physicians, we issued Intermediary Letter No. 372 to the carriers in April 1969 to increase their documentation substantiating charges made for inpatient hospital visits. BHI is now developing a manual instruction on verifying charges for actual visits shown on a claim, and for verifying the frequency of visits in per diem charge claims where the carrier has reason to suspect that visits were not made frequently enough to support the per diem charge.

6. Strengthen controls over the subcontracting activities of carriers by clarifying the circumstances under which prior approval by SSA is required for subcontracts awarded by its Medicare carriers

Language in our present agreements with Part B carriers and Part A intermediaries provides that the contractors cannot subcontract functions without the Secretary's approval. It also provides that purchase orders for supplies, equipment, and services and leases for equipment must have the written approval of the Secretary if such items are primarily to be used for the administration of the agreement and exceed $25,000 on a fixed fee basis or, regardless of cost, if they are on a cost or cost plus fixed fee basis.

In practice, we found that these requirements for the Secretary's approval were subject to interpretation as to the definition of "function" and that they also did not bring to us for prior approval subcontracts where less than half the work was for Medicare purposes even though the amount of Medicare costs involved were substantial. Consequently, in order to provide for more effective management and cost control of carrier

(and intermediary) subcontracts, we are negotiating revisions to the applicable provisions of our agreements with carriers (and intermediaries). The revisions being negotiated would require the contractors to submit for review and approval those subcontracts involving a major function or substantial Medicare funds, particularly those involving EDP, audit, or management consultation. At the same time, we wish to leave to contractor discretion those subcontracts of lesser functional significance or cost to Medicare.

A further step in tightening up our control over carriers who wish to contract for Part B EDP systems now available on the market was taken November 5, 1969. An instruction was issued at that time requiring the carriers wishing to contract for a Part B system to prepare specifications and secure written proposals from firms in the market that are able to supply a suitable system and the type of service needed. It was not feasible to take this step earlier because prior to that time there was only one firm which was offering to install and operate a Part B system.

[See GAO note.]

GAO note. Deleted comments relate to matters presented in draft report that have been revised.

PRINCIPAL OFFICIALS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE RESPONSIBLE FOR ADMINISTRATION OF THE ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE.		
Elliot L. Richardson	June 1970	Present
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
COMMISSIONER OF SOCIAL SECURITY.		
Robert M. Ball	Apr. 1962	Present
DIRECTOR, BUREAU OF HEALTH INSURANCE (note a):		
Thomas M. Tierney	Apr. 1967	Present
Arthur E. Hess	July 1965	Apr. 1967

[a]The Bureau of Health Insurance was a part of the Bureau of Disability and Health Insurance until September 1965. At that time, separate bureaus were established to handle the functions of the disability program and the health insurance program.

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